BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KATHY ANN WEAVER-NISSENBAUM AKA KATHY ANN WEAVER AKA KATHY ANN NISSENBAUM 28072 Daydream Way Valencia, CA 91354 Registered Nurse License No. 419654 Respondent	Case No. 2007-177

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as it's Decision in the above entitled matter.

This Decision shall become effective on March 27, 2008.

IT IS SO ORDERED March 27, 2008.

LaTracure W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

EDMUND G. BROWN JR., Attorney General
of the State of California
JENNIFER S. CADY
Supervising Deputy Attorney General
KIMBERLEE D. KING, State Bar No. 141813
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KATHY ANN WEAVER-NISSENBAUM AKA KATHY ANN WEAVER AKA KATHY ANN NISSENBAUM 28072 Daydream Way Valencia, CA 91354 Registered Nurse License No. 419654 Respondent.	Case No. 2007-177 OAH No. L-2007020801 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Ruth Ann Terry, M.P.H, R.N (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Kimberlee D. King, Deputy Attorney General.

2. Kathy Ann Weaver-Nissenbaum aka Kathy Ann Weaver aka Kathy Ann Nissenbaum (Respondent) is represented in this proceeding by attorney Phyllis Gallagher, whose address is Post Office Box 1551, Wrightwood CA 92397-1551.

3. On or about October 31, 1987, the Board of Registered Nursing issued Registered Nurse License No. 419654 to Kathy Ann Weaver-Nissenbaum aka Kathy Ann Weaver aka Kathy Ann Nissenbaum (Respondent). The License was in full force and effect at all times relevant to the charges brought in Accusation No. 2007-177 and will expire on October 31, 2005, unless renewed.

JURISDICTION

4. Accusation No. 2007-177 was filed before the Board of Registered Nursing (Board) , Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 19, 2006. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2007-177 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Accusation No. 2007-177 . Respondent also has carefully read, discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 2007-177, if proven at a hearing, constitute cause for imposing discipline upon her Registered Nurse license. For the purposes of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

Respondent agrees that her Registered Nurse license is subject to discipline and hereby surrenders her Registered Nurse License No. 419654 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further process.

CONTINGENCY

10. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

OTHER MATTERS

11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

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12. In consideration of the foregoing admissions and stipulations, the parties agree that the (Board) may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 419654, issued to Respondent Kathy Ann Weaver-Nissenbaum aka Kathy Ann Weaver aka Kathy Ann Nissenbaum is surrendered and accepted by the Board of Registered Nursing.

13. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

14. Respondent shall lose all rights and privileges as a registered nurse in California as of the effective date of the Board's Decision and Order.

15. Respondent shall cause to be delivered to the Board both her License wall and pocket license certificate on or before the effective date of the Decision and Order.

16. Respondent fully understands and agrees that if she ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2007-177 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

17. Upon reinstatement of the license, Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of Fifteen Thousand, five hundred, and seventy-eight dollars ($15, 578). Respondent shall be permitted to pay these costs in a payment plan approved by the Board.

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18. Should Respondent ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 2007-177 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

19. Respondent shall not apply for licensure or petition for reinstatement for three (3) years from the effective date of the Board of Registered Nursing's Decision and Order.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Phyllis Gallagher. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 6-6-07

Kathy Ann Weaver-Nissenbaum aka Kathy Ann Weaver aka Kathy Ann Nissenbaum (Respondent)
Respondent

I have read and fully discussed with Respondent Kathy Ann Weaver-Nissenbaum aka Kathy Ann Weaver aka Kathy Ann Nissenbaum the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: June 6, 2007

PHYLLIS GALLAGHER
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

DATED: January 7, 2008

EDMUND G. BROWN JR., Attorney General
of the State of California

JENNIFER S. CADY
Supervising Deputy Attorney General

KIMBERLEE D. KING
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: LA2004602320
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Exhibit A

Accusation No. 2007-177

BILL LOCKYER, Attorney General
of the State of California
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KIMBERLEE D. KING, State Bar No. 141813
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against: KATHY ANN WEAVER-NISSENBAUM, AKA KATHY ANN WEAVER, AKA KATHY ANN NISSENBAUM 28072 Daydream Way Valencia, CA 91354 Registered Nurse License No. 419654 Respondent.	Case No. 2007-177 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about October 31, 1987, the Board issued Registered Nurse License No. 419654 to Kathy Ann Weaver-Nissenbaum, aka Kathy Ann Weaver, aka Kathy Ann Nissenbaum (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and expires on October 31, 2007.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 states, in pertinent part:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [article 3 (commencing with section 2750)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in the practice regulated by this chapter [chapter 6 (commencing with section 2700)]."

5. Section 2764 states:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary suspension of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

6. Section 2811(b), provides in pertinent part, that each license not renewed in accordance with that section shall expire, but may within a period of eight years thereafter be reinstated.

7. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

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8. Section 2762 states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Section 4022 defines "Dangerous Drugs" as any drug that is unsafe for self-medication and which by federal or state law can be lawfully dispensed only on prescription.

10. Section 4060 states, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, or a physician assistant pursuant to Section 3502.1."

11. California Code of Regulations, title 16, section 1444, states:

"A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such . . . acts shall include but not be limited to the following:

. . . .

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"(c) Theft, dishonesty, fraud, or deceit. . . ."

12. Health & Safety Code section 11173(a), states that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge.

13. Health & Safety Code section 11173(b), states that no person shall make a false statement in any prescription, order, report, or record, required by this division.

14. Health and Safety Code section 11350 states, in pertinent part that except as otherwise provided in this division, every person who possesses any controlled substance which is a narcotic drug, unless upon the written prescription of a physician licensed to practice in this state, shall be punished by imprisonment in the state prison.

CONTROLLED SUBSTANCES

15. "Ativan" is a trade name for Lorazepam and is a dangerous drug as defined by section 4022. It is classified as a Schedule IV controlled substance as defined in Health and Safety Code section 11057(b)(13).

16. "Demerol," a narcotic analgesic, is a trade name for meperidine hydrochloride, a derivative of pethidine, and is a dangerous drug as defined by section 4022. It is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(17).

17. "Dilaudid" a narcotic analgesic, is a trade name for hydromorphone and is a dangerous drug as defined by section 4022. It is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(K).

18. "Morphine" is a narcotic analgesic and an opiate and is a dangerous drug as defined by section 4022. It is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(M).

19. "Morphine Sulfate" (alkaloid of opium) is a dangerous drug as defined in section 4022 of the Code. It is classified as a Schedule II controlled substance as listed in Health and Safety Code section 11055(b)(1)(m).

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20. "Percocet" is a trade name for oxycodone hydrochloride and oxycodone terephthalate with the non-narcotic substance acetaminophen and is a dangerous drug as defined by section 4022. It is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055(a)(1)(N).

21. "Tylenol #3" (generic - Codeine 30mg and Acetaminophen 500mg) is a dangerous drug as defined by section 4022. It is classified as a Schedule III controlled substance as listed in Health and Safety Code section 11056(e)(2).

22. "Vicodin" is a trade name for hydrocodone or Dihydrocodeinone and is a dangerous drug as defined by section 4022. It is classified as a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(3).

23. "Lortab" is another trade name for hydrocodone or Dihydrocodeinone and is a dangerous drug as defined by section 4022. It is classified as a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 (e) (3).

Saint John's Health Center, Santa Monica

24. Respondent began her employment at Saint John's Health Center, Santa Monica in 1985 and worked there until approximately August 26, 2000. Respondent began her shift from Saturday, 7:00 p.m. until Sunday, 7:00 a.m., and again on Sunday, 7:00 p.m., until Monday, 7:00 a.m. Respondent worked this shift on a consistent basis in the four (4) South unit.

FIRST CAUSE FOR DISCIPLINE

(Falsification, Grossly Incorrect or Grossly Inconsistent Entries)

25. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, subdivision (c), in that, while on duty as a registered nurse at Saint John's Health Center, Respondent falsified, or made grossly incorrect, or grossly inconsistent entries, in hospital and patient records as described herein:

a. Patient MR#L015439300

On or about July 31, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0537 hours, Respondent signed out two tablets of

Tylenol/Codeine #3 by entering her personalized access code into the Sure-Med[1/] automatic machine as reflected in the Sure-Med report. There was no Tylenol/Codeine #3 ordered for this patient by any Physician. Respondent did not account for the administration of Tylenol/Codeine #3 to this patient in any hospital record.

On or about July 31, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0054 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Percocet ordered for this patient by any Physician. Respondent did not account for the administration of Percocet to this patient in any hospital record.

b. Patient MR#L015004955

On or about July 31, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0053 hours, Respondent signed out two tablets of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about July 31, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0535 hours, Respondent signed out two tablets of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

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1. The Sure-Med System is an automated, computerized controlled substance/dangerous drug dispensable system. The medications are dispensed by the requestor, who has his or her own unique personalized access code, and who enters the patient's name, the medication, the amount and the date/time the medications are withdrawn.

c. Patient MR#L015468333

On or about July 31, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0053 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about July 31, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0535 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Percocet ordered for this patient by any Physician. Respondent did not account for the administration of Percocet to this patient in any hospital record.

d. Patient MR#L015434905

On or about July 31, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0536 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

e. Patient MR#L015503113

On or about July 31, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0536 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

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f. Patient MR#L015466873

On or about July 31, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0536 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

g. Patient MR#L015571748

On or about August 14, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0506 hours, Respondent signed out two tablets of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about August 14, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0515 hours, Respondent signed out Morphine 8mg/ml by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Morphine to this patient in any hospital record.

h. Patient MR#L015613615

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0213 hours, Respondent signed out two tablets of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about August 14, 2000, Respondent was on duty at this hospital, however this patient was not under her care. At 0505 hours, Respondent signed out two tablets of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0536 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report.

i. Patient MR#L015593924

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0506 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0516 hours, Respondent signed out 8mg/ml/of Morphine by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of 8mg/ml of Morphine to this patient in any hospital record.

j. Patient MR#L015581630

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0211 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0507 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

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k. Patient MR#L015569171

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0507 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

l. Patient MR#L015579162

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0505 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

m. Patient MR#L015578271

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0212 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet of Percocet for this patient. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0637 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet of Percocet for this patient Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0639 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet of Percocet for this patient Respondent did not account for the administration of Percocet to this patient in any hospital record.

n. Patient MR#L015456262

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0210 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

o. Patient MR#L015605876

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0211 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

p. Patient MR#L015585755

On or about August 14, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0505 hours, Respondent signed out one tablet of Tylenol/Codeine #3 by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of one tablet of Tylenol/Codeine #3 to this patient in any hospital record.

q. Patient MR#L015651524

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0352 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0610 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Lortab to this patient in the MAR.

r. Patient MR#L015658743

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0353 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

s. Patient MR#L015583768

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0353 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0610 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

t. Patient MR#L015649817

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0353 hours, Respondent signed out one tablet of Lortab by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. There was no Lortab ordered for this patient by any Physician. Respondent did not account for the administration of Lortab to this patient in any hospital record.

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u. Patient MR#L015599194

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0350 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet every three hours. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0610 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet every three hours. Respondent did not account for the administration of Percocet to this patient in any hospital record.

v. Patient MR#L015629801

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0354 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Physician's order was for only one tablet every three hours. Respondent did not account for the administration of Percocet to this patient in any hospital record.

w. Patient MR#L015556079

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0354 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

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x. Patient MR#L015617913

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0355 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

On or about August 21, 2000, Respondent was on duty at this hospital, however, this patient was not under her care. At 0611 hours, Respondent signed out two tablets of Percocet by entering her personalized access code into the Sure-Med System as reflected in the Sure-Med report. Respondent did not account for the administration of Percocet to this patient in any hospital record.

Providence Holy Cross Medical Center, Mission Hills

26. Respondent began her employment as a registered nurse at Providence Holy Cross Medical Center, Missions Hills on November 5, 2001. Respondent was terminated on January 31, 2003.

27. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, subdivision (c), in that, while on duty as a registered nurse at Providence Holy Cross Medical Center, Missions Hills, Respondent falsified, or made grossly incorrect, or grossly inconsistent entries, in hospital and patient records as described herein:

a. Patient #36258/ID #4148080

On or about December 28, 2002, at 1935 hours, Respondent signed out two tablets of Vicodin and documented the withdrawal in the Controlled Medication Disposition Record (CMDR). Physician's order was for only one tablet of Vicodin every six hours for pain. The administration of two tablets of Vicodin to this patient was documented at 2300 hours on December 28, 2002, however the entry was not signed.

On or about December 28, 2002, at 2300 hours, Respondent signed out one tablet of Restoril, but documented the withdrawal of one tablet of Lortab in the CMDR for this patient.

Physician's order was for 30 mg of Restoril prn for this patient. There was no order of Lortab for this patient. Respondent failed to account for the administration of Restoril or Lortab in any hospital record.

On or about December 29, 2002, at 0210 hours, Respondent failed to signed out or document any withdrawal of Vicodin in the CMDR for this patient. Physician's order was for one tablet of Vicodin every six hours. Respondent documented on the PRN Medication Record that an unknown quantity of Vicodin was "offered and refused." Respondent failed to account for the wastage of Vicodin and further failed to obtain a counter-signature for the wastage.

On or about December 29, 2002, at 0330 hours, Respondent failed to sign out or document any withdrawal of Vicodin in the CMDR for this patient. Physician's order was for one tablet of Vicodin every six hours. Respondent documented on the PRN Medication Record that an unknown quantity of Vicodin was "offered and refused." Respondent failed to account for the wastage of Vicodin and further failed to obtain a counter-signature for the wastage.

On December 29, 2002, at 0430 hours, Respondent signed out Demerol 25 mg and documented the withdrawal in the CMDR for this patient. Physician's order was for Demerol 25 mg by IV every six hours (ordered at 4 p.m. on December 28, 2002; prior to 4 p.m., the order was Demerol 25 mg by IV every four hours). Respondent documented that she administered the Demerol to the patient at 0530 hours. Respondent also altered entries in the PRN Medication Record which changed the administration of Demerol 25 Mg on December 28, 2002, at 0200 hours to December 27, 2002, at 0100 hours, made the entry regarding the time of the administration of Demerol 25 mg on December 28, 2002, inconsistent and illegible, and changed the administration of Demerol 25 mg on December 29, 2002, at 2200 hours to 2400 hours.

b. Patient #221257/ID #4187526

On or about January 10, 2003, at 2240 hours, Respondent signed out two (2) tablets of Vicodin in the CMDR for this patient. Physician's order was Vicodin (2 tablets) for this patient. Respondent failed to account for the administration of Vicodin in the PRN Medication Record .

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Granada Hills Community Hospital, Granada Hills

28. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, subdivision (c), in that, while on duty as a registered nurse at Granada Hills Community Hospital, Granada Hills, Respondent falsified, or made grossly incorrect, or grossly inconsistent entries, in hospital and patient records as described herein

a. Patient 2

On or about April 20, 2003, at 1930 hours, Respondent signed out Morphine Sulfate 4mg (2mg administered, 2mg wasted) and documented the withdrawal on the Controlled Substance Administration Record (CSAR) for this patient. Respondent failed to obtain a countersignature for the wastage of 2mg of Morphine Sulfate. Physician's order was for Morphine Sulfate 2mg IV every two hours as needed for pain for this patient. On or about April 20, 2003, at 1900 hours, Respondent documented administration of Morphine Sulfate 2mg to this patient which is inconsistent with the entry on the CSAR.

On or about April 20, 2003, at 2130 hours, Respondent signed out Morphine Sulfate 4mg (2mg administered, 2mg wasted) and documented the withdrawal on the CSAR for this patient. Respondent failed to obtain a countersignature for the wastage of 2mg of Morphine Sulfate. Respondent failed to account for the disposition of Morphine Sulfate 4mg in any hospital records.

On or about April 20, 2003, at 2400 hours, Respondent signed out Morphine Sulfate 2mg and documented the withdrawal on the CSAR for this patient. Respondent failed to account for the disposition of Morphine Sulfate 2mg in any hospital records.

On or about April 20, 2003, at 0200 hours, Respondent signed out Morphine Sulfate 2mg and documented the withdrawal on the CSAR for this patient. Respondent failed to account for the disposition of Morphine Sulfate 2mg in any hospital records.

On or about April 20, 2003, at 0420 hours, Respondent signed out Morphine Sulfate 2mg and documented the withdrawal on the CSAR for this patient. Respondent failed to account for the disposition of Morphine Sulfate 2mg in any hospital records.

On or about April 20, 2003, at 0600 hours, Respondent signed out Morphine Sulfate 4mg (2mg administered, 2mg wasted) and documented the withdrawal on the CSAR for this patient. Respondent failed to obtain a countersignature for the wastage of 2mg of Morphine Sulfate. Respondent failed to account for the disposition of Morphine Sulfate 4mg in any hospital records.

b. Patient 3

On or about April 26, 2003, at 2400 hours, Respondent signed out Lorazepam (Ativan) 2mg and documented that "IV infilled Medication not given discard" on the CSAR for this patient. This entry was countersigned in the waste verification category on the CSAR.

On or about April 26, 2003, at 2410 hours, Respondent signed out Lorazepam (Ativan) 2mg and documented the withdrawal on the CSAR for this patient. Physician's order was Ativan 1mg IM every six hours as needed for agitation for this patient. Respondent documented a late entry on this patient's MAR for administration of Ativan 1mg on or about April 26, 2003, at 1930 hours, which is inconsistent with the entry on the CSAR.

On or about April 26, 2003, at 0400 hours, Respondent signed out Lorazepam (Ativan) 2mg and documented the withdrawal on the CSAR for this patient. Respondent failed to account for the disposition of Ativan 2mg in any hospital records.

On or about April 27, 2003, at 0130 hours, Respondent documented administration of Ativan 1mg to this patient on the MAR. There was no withdrawal of Ativan 1mg on the CSAR for this patient to correspond with this medication administration time.

On or about April 27, 2003, at 0300 hours, Respondent signed out Lorazepam (Ativan) 2mg (1mg administered and 1mg wasted) and documented the withdrawal on the CSAR for this patient. On or about April 27, 2003, at 0630 hours, Respondent documented administration of Ativan 1mg on the MAR to this patient which is inconsistent with the entry on the CSAR.

On or about April 27, 2003, at 2200 hours, Respondent signed out Lorazepam (Ativan) 2mg (1mg administered and 1mg wasted) and documented the withdrawal on the CSAR for this patient. On or about April 27, 2003, at 2000 hours, Respondent documented

administration of Ativan 1mg on the MAR to this patient which is inconsistent with the entry on the CSAR.

c. Patient 4

On or about April 26, 2003, at 0435 hours, Respondent signed out Morphine Sulfate 4mg and documented the withdrawal on the CSAR for this patient. Physician's order was Morphine Sulfate 2mg IV every two hours as needed for the pain for this patient. Respondent failed to account for the disposition of Morphine Sulfate 4mg in any hospital records.

d. Patient 5

On or about April 26, 2003, at 1930 hours, Respondent signed out Morphine Sulfate 8mg (2mg administered, 6mg wasted) and documented withdrawal on the CSAR for this patient. Physician's order was Morphine Sulfate 2mg IVP every four hours as needed for the pain for this patient. Respondent charted a late and altered entry which indicates that she administered Morphine Sulfate 2 mg to this patient on or about April 26, 2003 at 2000 hours.

On or about April 26, 2003, at 2300 hours, Respondent signed out Morphine Sulfate 4mg and documented that she administered 4 mg on the CSAR which is an incorrect dose for this patient. This entry was countersigned in the wasted category on the CSAR. Respondent documented a late entry on this patient's MAR for administration of Morphine Sulfate 2mg on or about April 26, 2003, at 2300 hours, which is inconsistent with the entry on the CSAR.

On or about April 26, 2003, at 0430 hours, Respondent signed out Morphine Sulfate 4mg and documented the she administered 4 mg on the CSAR which is an incorrect dose for this patient. Respondent failed to account for disposition of Morphine Sulfate 4mg in any hospital records.

On or about April 26, 2003, at 0500 hours, Respondent signed out Morphine Sulfate 4mg and documented the she administered 4mg on the CSAR which is an incorrect dose for this patient. Respondent failed to account for disposition of Morphine Sulfate 4mg in any hospital records.

On or about April 27, 2003, at 2000 hours, Respondent signed out Morphine Sulfate 4mg and documented the she administered 4mg on the CSAR which is an incorrect dose

for this patient. Respondent failed to account for disposition of Morphine Sulfate 4mg in any hospital records.

e. Patient 6

On or about April 27, 2003, at 1930 hours, Respondent signed out Morphine Sulfate 4mg and documented that she administered 4mg on the CSAR which is an incorrect dose for this patient. Physician's order was Morphine Sulfate 2mg IVP every hour as needed for severe pain for this patient. On or about April 27, 2003, at 1900 hours, Respondent charted the administration of Morphine Sufate 2mg on the MAR which is inconsistent with the entry on the CSAR. Respondent failed to account for disposition of Morphine Sulfate 2mg in any hospital records.

On or about April 27, 2003, at 2200 hours, Respondent signed out Morphine Sulfate 4 mg and documented that she administered 4mg to this patient and wasted 2mg on the CSAR which is an inconsistent entry. The entry was countersignatured in the waste verification category on the CSAR. On or about April 27, 2003, at 2100 hours, Respondent documented administration of Morphine Sulfate 2mg to this patient which is inconsistent with the entry on the CSAR.

On or about April 27, 2003, at 0230 hours, Respondent signed out Morphine Sulfate 4mg and documented that she administered 4mg on the CSAR which is an incorrect dose for this patient. Respondent failed to account for disposition of Morphine Sulfate 4mg in any hospital records.

On or about April 27, 2003, at 0515 hours, Respondent signed out Morphine Sulfate 2mg and documented the withdrawal on the CSAR for this patient. Respondent failed to account for disposition of Morphine Sulfate 2mg in any hospital records.

f. Patient 8

On or about May 3, 2003, at 2130 hours, Respondent signed out Morphine Sulfate 4mg and documented that she administered 4mg on the CSAR, for this patient. Physician's Order was Morphine Sulfate 2mg IV for chest pain, may give up to 4mg per hour for this patient. On May 3, 2003 at 2130 hours, Respondent charted the administration of Morphine Sulfate 2mg on

the MAR which is inconsistent with the entry on the CSAR. Respondent failed to account for disposition of Morphine Sulfate 2mg in any hospital records.

On or about May 3, 2003, at 2330 hours, Respondent signed out Morphine Sulfate 4mg and documented that she administered 4mg on the CSAR for this patient. Respondent documented a late entry on this patient's MAR for administration of Morphine Sulfate 2mg on or about May 3, 2003, at 2330 hours, which is inconsistent with the entry on the CSAR. Respondent failed to account for disposition of Morphine Sulfate 2mg in any hospital records.

On or about May 3, 2003, at 2340 hours, Respondent signed out Lorazepam (Ativan) 2mg (1mg administered, 1mg wasted) and documented withdrawal on the CSAR for this patient. Physician's order was Ativan 1mg IVP every six hours as needed for agitation for this patient. On or about May 3, 2003, at 2245 hours, Respondent documented administration of Ativan 1mg on the MAR to this patient which is inconsistent with the entry on the CSAR.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

29. Respondent is subject to disciplinary action pursuant to section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in section 2762, subdivision (a), in that Respondent obtained controlled substances, by fraud, deceit, misrepresentation or subterfuge in violation of Health and Safety Code sections 11173, subdivisions (a) and (b), when she took the controlled substances from Saint John's Health Center, Santa Monica; Providence Holy Cross Medical Center, Mission Hills; and Granada Hills Community Hospital, Granada Hills, as set forth above in paragraphs 24 through 28.

THIRD CAUSE FOR DISCIPLINE

(Possession of Controlled Substances and Dangerous Drugs)

30. Respondent is subject to disciplinary action pursuant to section 2761, subdivision (a), as defined in section 2762, subdivision (a), and 4060, on the grounds of unprofessional conduct, in violation of Health and Safety Code sections 11350 in that Respondent obtained and possessed the controlled substances without physicians' orders, as set forth above in paragraphs 24 through 28.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

31. Respondent is subject to disciplinary action pursuant to section 2761 subdivision (a) in that while employed as a registered nurse by Saint John's Health Center, Santa Monica; Providence Holy Cross Medical Center, Mission Hills; and Granada Hills Community Hospital, Granada Hills, she committed acts of unprofessional conduct by falsifying hospital records and diverting dangerous drugs and controlled substances for her own personal use as set forth above in paragraphs 24 through 28.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

32. Respondent is subject to disciplinary action pursuant to section 2761 subdivision (a) (1) in that while employed as a registered nurse by Saint John's Health Center, Santa Monica; Providence Holy Cross Medical Center, Mission Hills; and Granada Hills Community Hospital, Granada Hills, she committed acts of gross negligence and/or incompetence by her actions set forth above in paragraphs 24 through 28.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 419654, issued to Kathy Ann Weaver-Nissenbaum, aka Kathy Ann Weaver, aka Kathy Ann Nissenbaum.

2. Ordering Kathy Ann Weaver-Nissenbaum, aka Kathy Ann Weaver, aka Kathy Ann Nissenbaum to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 12/19/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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